# California MCH
# Five Year Needs Assessment

# Guidelines & Indicator List for MCAH Jurisdictions

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# Maternal and Child Health Community Health Assessment and Local Plan Development Guidance
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## I. Background

The Federal Maternal and Child Health (MCH) Bureau requires all states receiving Title V Block Grant funding to submit a statewide needs assessment every five years. The MCH population that this assessment process addresses includes: (1) pregnant women, mothers, and infants up to age one; and (2) children (including adolescents).

California is unique among the states in terms of its size and diversity of population, geography, and maternal and child health needs. Therefore, the State MCH Branch depends on receiving input from all of its 61 local MCH jurisdictions in order to produce a comprehensive analysis that describes the State's various public health issues and unmet needs, some of which may be specific to a given area. The purpose of this document is to help your local MCH jurisdiction to produce a succinct yet thorough needs assessment and action plan for meeting those needs.

Your local assessment is to be completed under the direction of the MCH Director in collaboration with the Health Officer, MCH program coordinators, and all appropriate public and private organizations. The local MCH community needs assessment report for the next five year cycle (2005-2009) must be submitted to the Family Health Outcomes Project by **June 30, 2004.**

After completion of the needs assessment, each jurisdiction is responsible for preparing an action plan that maps out the steps to address the identified needs. Your progress toward those goals will be monitored as part of the justification for program activities in the annual MCH Application for Allocation. Supplemental guidelines for the action plan will be forthcoming. The action plan is due **June 30, 2005.**

## II. Guidelines and Technical Assistance

The Family Health Outcomes Project (FHOP) will provide you with health status indicator data to minimize the local jurisdiction data collection burden and to ensure standardized reporting and analysis. In order to support the completion of your five year needs assessment, FHOP will:

- Serve as the contact to respond to questions and provide technical assistance related to the five year needs assessment and action plan;
- Provide feedback on draft assessments and plans;
- Provide on its website standardized data for the indicators that the jurisdictions are required to review;
- Provide on its website the revised Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003). The guide provides a step-by-step process of community assessment and plan development;
- Provide updates in the FHOP newsletter on newly available data and assessment tools;
- Continue to provide training relevant to the assessment and planning process.

FHOP contact information

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## III. The Planning and Assessment Process

The five year needs assessment document should not exceed 32 pages, plus any additional priority problem analyses and appendices. We urge MCH Directors and staff to refer to and use the FHOP website frequently during the process in order to access data, the planning guide Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003)*, and other helpful materials and tools.

See the attached MCH Five Year Needs Assessment Report Outline for the required report content and format. We recommend preparing the report, as much as possible, as the assessment process proceeds and produces data and decisions.

*Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003) is referred to throughout this guidance as "the planning guide." Where a "Chapter" is referred to, it is a chapter of the planning guide.

# MCH Five Year Needs Assessment Report Outline

The following is an outline of the recommended content and format for the MCH Five Year Needs Assessment Report. Voluminous narrative reporting is not encouraged; rather, use tables and bulleted information wherever appropriate. Suggested page limits are included. The planning guide* chapter references are included to provide additional guidance as needed. In some sections a paragraph is included to describe the planning process that would contribute to the content of the section.

The report should have seven sections:

I. Summary/Executive Report
II. Description of the MCH Community Health Assessment Process
III. MCH Planning Mission Statement and Goals
IV. MCH Community Assessment
V. Priority MCH Problems/Needs in the Jurisdiction
VI. Preliminary Problem Analysis for the Identified Local Priority Problems
VII. Appendices

Section details:

## I. *Summary/Executive Report (1-2 pages)*

This section should include:

A. Purpose of the assessment
B. Description of the assessment and prioritization process
C. Mission and goals agreed upon by the planning group
D. Highlights of the assessment findings
E. Priority MCH problems/needs

## II. *Description of the MCH Community Health Assessment Process (1-3 pages) Reference: Chapter I*

This section should:

A. Describe the planning group/how it was recruited/selected
B. Describe what or how partnerships/collaborations were used
C. Briefly describe the planning processes
D. Describe how community input was obtained

**Process:** Convene a planning group to conduct an inclusive assessment and planning process. Local jurisdictions are required to obtain public input into its MCH assessment, including input from citizens and family members. The jurisdiction may obtain this input in several ways. A broadly representative planning group or collaborative of stakeholders that includes consumers

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and advocates is recommended to meet this requirement. Alternatively, the local MCH program may be able to partner or build upon other collaborative efforts to assess community needs. See Chapter I for guidance about forming and facilitating a planning group and for alternative options.

## III. *MCH Planning Mission Statement and Goals (1 page) Reference: Chapter I*

This section should:

A. Briefly describe the process for developing the Mission and Goals
B. Present the MCH Mission and Goals

**Process:** The planning group should review any previous mission and goals and establish the current MCH mission and goals to guide the work of the assessment.

## IV. *MCH Community Assessment* (25 page maximum) *Reference: Chapter II*

This section should include:

**A. Community health profile (2-5 pages) Reference: Chapter II**

1. The profile should include indicators of the overall population's socio-demographic status, health status, health risk factors, and access to health and social services. It provides the context in which MCH population health needs will be identified and will highlight factors (e.g., geographic, political or social) that need to be considered when responding to health problems.
2. Some jurisdictions may be conducting an assessment of community assets to identify the resources and strengths within a community. If a community assets assessment has been done, summarize the findings. Alternatively, if your local Public Health Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to use the process and data specific to the MCH community profile in this section.
3. See Chapter II for guidance on content and the FHOP website for community health profile examples.

**B. Community resources assessment (1-4 pages) Reference: Chapter II**

1. For each of the two MCH populations: 1) pregnant women, mothers, and infants up to age one; and 2) children (including adolescents):
   a. Identify concerns regarding access to health care and health-related services from the perspectives of financial access, cultural acceptability, availability of prevention and primary care services, and availability of specialty care services when needed.
   b. Assess and describe the availability of care. Discuss, as appropriate, shortages of specific types of health care providers, such as primary care physicians, nutritionists, public health or visiting nurses, etc. This should not be a list of providers and services, but rather should identify gaps and needs. A table, chart or map of the resources can be included as an appendix. See Chapter II for guidance on content and the FHOP website for examples.
   c. One way to do this would be to update the previous MCH Five Year Needs Assessment "Health Services Systems Profile" or a description of community resources recently done in the county for another purpose. Alternatively, if your local Public Health Department is implementing the "Mobilization for Action

through Planning and Partnership (MAPP)" planning process you may wish to use the process/data specific to the MCH community resources assessment in this section.

**C. Review the State required MCH indicators (See Appendix A) (2-7 pages)**

1. Provide a list and a discussion of the required indicators (Appendix A) that you identify as local MCH problem areas based on quantitative and qualitative analyses.
   (a) Quantitative Analysis. For each indicator, review the data available under *California MCH Data* on the FHOP website for the jurisdiction. Using this data:
      (i) For each indicator, compare your local values with the standards provided, which will be the Healthy People 2010 goal and/or Statewide data. Include a test for statistical significance (as small number limitations allow). Complete and include, in an appendix to this section, the required form comparing local data to Healthy People 2010 or Statewide data. (The required form will be available on the FHOP website in August.)
      (ii) Analyze the data for significant differences among subgroups or trends over time. In the report, comment on the significance of observed trends and any differences observed in age or racial subgroups for each required indicator. At least five years of data are required to assess trends. Refer to FHOP's new guidelines Do We Have a Trend? A Beginner's Guide to Analysis of Trends in Community Indicators that is posted on the FHOP web site under Reports/Guidelines. This document describes how to review indicator data over time, use an EXCEL function to select an appropriate trend line, and determine the significance of a trend. In the fall, FHOP will begin to post EXCEL tables that contain updated information for the required indicators overall and for age and race/ethnic subgroups where possible and relevant, along with rates and confidence intervals. For the major summary indicators (e.g. infant mortality, LBW) trend graphs with confidence intervals will be produced. In addition, FHOP's EXCEL data templates can be used to analyze indicator data and produce graphics for those indicators not included in the FHOP tables, or for subgroups in the tables for which trend graphs were not produced. **NOTE** that counties with fewer than 10 cases over three years for any of the indicators should not use the templates for those indicators and will not be able to adequately assess trends. These counties can use raw numbers and case review or qualitative data to describe the situation in the county regarding these areas
      (iii) Indicators that are significantly worse than the standard, or that have significant downward trends, should be included in the list of MCH problems from which the planning group selects the local priority problems. If available, data from other sources, such as locally conducted surveys, can also be considered in the quantitative analysis.
   d. Qualitative Analysis
      i. Include a review of any qualitative data collected from individuals and organizations with an understanding of the health needs of the community and the barriers to obtaining better public health. Report the results of qualitative needs analysis methods and describe how these results confirm, conflict with, or enhance the results of the quantitative analysis.

**D. Optional Topics (1-4 pages*)* Reference: Chapter II**

1. Provide a list and discussion of additional MCH indicators or topics, such as those listed at the end of Appendix A, that you identify as local problem areas as a result of the local community planning group's process or other method (see Chapter II). Include a summary analysis for each identified area. Include identified issues in the list of MCH problems.

**E. Assessment of MCH capacity (1-4 pages) Reference: FHOP Website**

1. Provide a summary description of your local MCH program capacity. Determine the capacity of the local MCH program for carrying out the core MCH activities. These include the ability to:
   a. monitor local MCH population health status;
   b. diagnose and investigate MCH problems in the community;
   c. inform, educate and empower people about MCH issues;
   d. mobilize community partnerships to identify and solve MCH-related problems;
   e. develop policies and plans that support MCH related health efforts;
   f. link women and children to needed health and social services;
   g. evaluate the effectiveness, accessibility and quality of MCH population-based health services.
2. Assess the cultural competency of your MCH program.
3. Briefly describe current issues in the public and/or private health care sector that have an impact on the MCH program's roles.
4. We recommend using the tool provided on the FHOP website (available in September) to assist your assessment. If your local Public Health Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to summarize the process/data specific to the MCH capacity assessment in this section.

**F. Identification of the Problems/Unmet Needs of the Local MCH Population (1-3 pages) Reference: Chapter II**

1. Synthesize the findings from sections A-E above.
   a. This should include assessment of major morbidity, mortality, health and other related risk factors, protective factors, gaps and disparities.
   b. Identify major problem areas within the MCH population as a whole and for significant sub-populations. Where possible, examine issues by race/ethnicity, age, health insurance status, type of health insurance, socioeconomic status and/or subcounty geographic area (zip code or census).
   c. Identify the unmet needs/problems of:
      i. pregnant women, mothers, and infants;
      ii. children, including adolescents.
   d. Present major findings in a bulleted or other summary format.

**Process:** Generally, MCH staff will develop the community profile, the community resource assessment and the local MCH capacity assessment**.** We recommend that where possible you begin with previous MCH profiles or assessments or those recently done in the county for another purpose. Staff (this may be in conjunction with a workgroup of the planning group) should review the State's list of required MCH indicators and optional indicator/assessment areas. For each required indicator, review the jurisdiction's data as described above. The results of the analysis of the indicator data should be reviewed by the planning committee and included in the local assessment report. The planning group may identify additional MCH indicators

relevant to local problems/needs or conduct assessments such as surveys to assist in assessing community health and health systems status. Both quantitative and qualitative data may be collected. Refer to Chapter II for a complete description of the process of identifying and selecting indicators and for tools that may assist you. The results of the analysis of the data compiled should be organized in a user friendly presentation to be reviewed by the planning group and a summary of significant findings and decisions based on these findings included in the assessment report as outlined above.

## V. *Priority MCH Problems/Needs in the Jurisdiction (1-2 pages) Reference: Chapter II and its Appendix II-I*

This section should:

A. Provide the final list of priority problems that will be addressed in the five year plan. Use clearly and plainly stated phrases, such as "The infant mortality rate for minorities should be reduced" or "Reduce the barriers to the delivery of care for pregnant women."
B. Briefly describe the process and rationale used to set priorities among the unmet needs/problems identified

**Process: Set priorities among identified health problems**. Present the health problem and service delivery data to the local planning group and have the group select the problems/needs that MCH will address as priorities during the next five year cycle. Use an inclusive process to set 2 to 7 priorities among the identified problems, as appropriate to the size and resources of the jurisdiction. Take into account your MCH program's capacity to achieve selected priorities. To set priorities among the identified problems, use an objective, systematic method such as the suggested prioritization process and tool included in Chapter II, and Appendix II-I. These priorities will receive targeted efforts for improvement and will be addressed in the action plan, the second component of the MCH assessment and planning process (due June 30, 2005).

## VI. *Preliminary Problem Analysis for the Identified Local Priority Problems. (2-3 pages for each priority problem) Reference: Chapter III*

This section should include:

A. A preliminary problem analysis for at least one identified priority problem. If time and resources permit, prepare a preliminary analysis for each of the priority problems. For each problem analysis done include the following:
    1. A brief statement of the problem and a preliminary problem analysis diagram. The diagram should identify direct precursors (causal factors), secondary precursors (personal, family, institutional and social risk factors) and tertiary factors (societal factors, systems issues, policies) that contribute to the observed poor outcome or condition as identified in the staff group or a planning group subcommittee designated to review the data
    2. Provide a list of the additional data/information the group identified as needed to understand the contributors to the problem or to identify effective interventions (i.e., additional data about the population most affected by or at risk for the problem or research about potential intervention points in the causal pathways and interventions) If there is a data collection/research plan include it as an appendix to this section

B. If your group is able to compile the additional data and research and continue with the process during this assessment year, summarize the result of the problem analysis process. In this case, include the final problem analysis diagram showing the selected causal pathway or pathways and intervention points for which interventions will be developed. Include a summary explanation. If the group does not get this far along in the process, it will be included in your next year's report/plan.

**Process:** The planning group should be involved in developing a preliminary problem analysis for at least one of your priority problems. Refer to Chapter III to review the components of the facilitated problem analysis process. With your planning group, use the assessment data to draft the problem analysis diagram. Where data are not available, brainstorm other factors from the planning group member's experience or from review of research and best practices literature. Develop a plan to complete the data collection and to do a literature or web review of the problem, its precursors, and potential interventions. This will give you a head start on the planning activities you will have to complete in the next funding year.

**VII.** ***Appendices***

Include appendices as indicated above and any other materials that you wish to be reviewed

# Appendix A:
# Indicators for MCH Five Year Needs Assessment

## Required Indicators

| | |
|---|---|
| **Birth** | |
| 1. Number of births & fertility rates | Birth file |
| 2. Number and teen birth rate per 1,000 females | Birth file |
| a) age 12-14 | |
| b) age 15-17 | |
| c) age 18-19 | |
| d) age 15-19 | |
| 3. Number & percent low birth weight (live births) | Birth file |
| 4. Number & percent very low birth weight (live births) | Birth file |
| 5. Number & percent preterm births (less than 37 weeks gestation) | Birth file |
| 6. Number & percent of births occurring within 24 months of a previous birth | Birth file |
| a) entire population | |
| b) age 12-19 | |
| 7. Number & percent of teen births to women who were already mothers | Birth file |
| **Death** | |
| 8. Perinatal death rate | Fetal Death & Death file |
| 9. Neonatal deaths (#) and death rate (per 1,000 live births) *[birth - <28 days]* | Death file |
| 10. Post-neonatal deaths (#) and death rate (per 1,000 live births) *[>=28 days - 1 year]* | Death file |
| 11. Infant deaths (#) and death rate (per 1,000 live births) *[birth - 1 year]* | Death file |
| 12. Deaths (#) and death rate per 100,000 | Death file |
| a) age 1-14 | |
| b) age 15-19 | |
| **Prenatal/postnatal care** | |
| 13. Number & percent prenatal care in first trimester (live births) | Birth file |
| 14. Number & proportion of women (age 15-44) with adequate prenatal care (Kotelchuck index) | Birth file |
| 15. Percent of women exclusively breastfeeding at the time of hospital discharge | Genetic Disease |

# Appendix A:
# Indicators for MCH Five Year Needs Assessment

| | |
|---|---|
| **Health** | |
| 16. Percent of children and adolescents without health insurance (age 0-18) | CHIS |
| 17. Percent of children without dental insurance (age 2-11) | CHIS |
| 18. Percent of children who have been to the dentist in the past year (age 2-11) | CHIS |
| 19. Percent of children and adolescents youths who are overweight | CHDP |
| a) age 5-11 | |
| b) age 12-19 | |
| 20. Rate of children hospitalized for asthma per 10,000 children | OSHPD |
| a) age < 4 | |
| b) age 5-18 | |
| 21. Rate per 1,000 women aged 15-19 with a reported case of chlamydia | STD Branch |
| 22. Rate of children hospitalized for mental health reason per 10,000 children | OSHPD |
| a) age 5-14 | |
| b) age 15-19 | |
| **Injuries** | |
| 23. Number and rate of hospitalizations for all non-fatal injuries, by age group | OSHPD |
| a) age <=14 | |
| b) age 15-24 | |
| 24. Rate of non-fatal injuries due to motor vehicle accidents | OSHPD |
| a) age <= 14 | |
| b) age 15-24 | |
| **Other** | |
| 25. Number of children living in foster care | DSS |
| 26. Percent of children in poverty (age 0-19) | Census 2000 DOF |
| 27. Percent of women 18 years or older reporting intimate partner physical abuse in the last 12 months | California Women's Health Survey |

**Appendix A:**
**Indicators for MCH Five Year Needs Assessment**

## Optional Topics

**MCH jurisdictions may want to consider including a discussion of other maternal and child health topics in your needs assessment reports. Examples of optional topics are shown below. FHOP is investigating data availability for some of these optional topics; if and when these data become available, jurisdictions will be notified. If your jurisdiction has done research or surveillance on these or other topics that are locally important, a discussion of the findings would be very helpful to the State in its Statewide assessment.**

1. Percent of children/adolescents who report at least 20 minutes of physical activity 3 or more days per week.
   *Note:* The California Department of Health Services Physical Activity Guidelines for Children, Youth and Adults recommends that "Elementary school children should accumulate at least 30-60 minutes of age and developmentally appropriate physical activity on all or most days of the week," and "Adolescents should engage in at least 60 minutes of moderate to vigorous physical activity per day on most days of the week. Thirty minutes of physical activity per day should be viewed as a minimum. One hour per day represents a more favorable level."
2. Number & percent of children 19 to 35 months of age who have received full schedule of age appropriate immunizations.
3. Incidences of vaccine-preventable diseases.
4. Indicators of mental health problems, e.g., suicide, depression, etc.
5. Rates/issues regarding perinatal substance abuse.
6. Rates/issues regarding gestational diabetes.
7. Issues regarding oral health, such as rates of sealant application in children, access to dental care, rate of children who have seen a dentist prior to starting school, etc.
8. Indicators of youth resiliancy, such as a close relationship with a caring adult, high expectations, and opportunities for meaningful participation.
9. Others?

Data Source Glossary

CHIS: California Health Interview Survey
OSHPD: Office of Statewide Planning and Development
DSS: Department of Social Services
DOF: Department of Finance